Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

Eligibility Operations Memo 02-20
December 23, 2002

TO: MassHealth Eligibility Operations Staff

FROM: Russ Kulp, Assistant Commissioner, Member Services

RE: **Changes to MassHealth Basic and MassHealth Buy-In Eligibility Rules**

Introduction

The Massachusetts Legislature has enacted into law a change in the eligibility requirements for MassHealth Basic and MassHealth Buy-In coverage for persons under the age of 65. Persons who are under the age of 65, and who are considered "long-term unemployed" will no longer be eligible for MassHealth Basic or MassHealth Buy-In unless they are:

- identified by the Department of Mental Health (DMH) to the Division as receiving services or as being on a waiting list to receive services from the DMH; are "long-term unemployed," and have income at or below 100 percent of the federal poverty level; or
- receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Department of Transitional Assistance.

Special Status Aliens

Special status aliens who meet the eligibility requirements at 130 CMR 519.008 are not affected by this change in eligibility rules.

Category 35

MassHealth members who are identified by the DMH as receiving services or as being on a waiting list to receive services from the DMH are identified on MMIS as Category 35.

Advance Notice

On January 3, 2003, the Division will send an advance notice packet to affected MassHealth members. The advance notice will tell members of the change in eligibility rules for MassHealth Basic and MassHealth Buy-In, and that the effective date for this change will not be before February 15, 2003, or later than April 1, 2003. This notice will not contain appeal rights. The notice packet also includes a MassHealth Eligibility Update Form, a MassHealth Permission to Share Information form, a UNIV-5 multilingual notice, and specially color-coded MassHealth Adult

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(continued on next page)

Advance Notice (cont.)

Disability Supplement. Copies of the notice, the Eligibility Update Form, and the Permission to Share form are attached to this memo.

Eligibility Review Process

The purpose of this mailing is to afford members who might still be eligible under the new eligibility rules, or under another coverage type, the opportunity to have their eligibility for MassHealth reviewed if they return a completed MassHealth Eligibility Update Form to the Division.

- If the member answers "YES" to Question 1 and provides pregnancy information, update the PRG event on MA21 with member's pregnancy information and schedule an eligibility determination.
- If the member answers "YES" to Question 2 and provides caretaker information, update the HOH screen with the appropriate relationship coding. If the member is the caretaker of another household member, enter CTAKER as the member's relationship code and CAREOF for the child who is being cared for by this member. Schedule an eligibility determination.
- If the member answers "YES" to Question 3 and provides HIV information, update HIV event with the member's HIV information and schedule an eligibility determination.
- If the member answers "YES" to Question 4 and submits a completed Disability Supplement, process the supplement using current procedures. Update the member on MA21 by entering the Sent to DDU date and scheduling an eligibility determination. Forward the supplement to DES, as usual.

Returned Disability Supplement

Members who have returned a completed Disability Supplement, which has been sent to Disability Evaluation Services (DES), will have their MassHealth Basic or Buy-In eligibility pend until a determination is made by DES on their disability.

Permission to Share Information

If a member completes and returns the MassHealth Permission to Share Information form and names an individual or group with whom the Division can share the member's information, list that individual or group as the contact person on MA21.

If a member completes and returns the Permission to Share Information form and indicates on the form that he or she authorizes the Division to share disability and any other medical information, make a copy of the Permission to Share Information form and send it to DES along with the Disability Supplement.

Change to Notices

After January 3, 2003, approval notices, downgrade notices from any coverage type to Basic or Buy-In, and upgrade notices from Limited to Basic or Buy-In will include language telling members of the implementation date of and the change in eligibility rules for Basic and Buy-In.

Implementation of New Rules and Appeal Rights

Fourteen days before the implementation date of the revised Basic and Buy-In eligibility regulations, MA21 will perform an eligibility determination for all current Basic and Buy-In members using the new eligibility rules. Members who lose Basic or Buy-In eligibility based on the new rules will receive an MA21 notice that provides appeal rights.

Questions

If you have any questions about this memo, please have your MassHealth Enrollment Center designee contact the MassHealth Policy Hotline at 617-210-5331.

_____ Office
MEC Street Address
MEC City, State, Zip

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance

<Date: _____>
<SSN: _____>
<MEC: _____
<NUM: _____ Type: _____>

<Member's Name>
<Street Address>
<City, State, Zip>

This is an important message about your MassHealth benefits.

The Division of Medical Assistance will change the rules that we use to decide who is eligible for MassHealth Basic and MassHealth Buy-In for persons who are under the age of 65.

The effective date of this change will be no sooner than February 1, 2003, and no later than April 1, 2003. The exact effective date will be decided by the Massachusetts Legislature. This change is being made because of a law passed by the Massachusetts Legislature.

If you are under the age of 65 and getting coverage under MassHealth Basic or MassHealth Buy-In as a person who is "long-term unemployed," you will no longer be eligible for MassHealth Basic or Buy-In unless you:

- have been identified by the Department of Mental Health (DMH) as getting services or as being on a waiting list to get services from the DMH, are "long-term unemployed", and have income at or below 100% of the federal poverty level; or
- are getting Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Department of Transitional Assistance.

Because current information in our files show that you are NOT one of the persons who can get MassHealth Basic or Buy-In after the effective date, your MassHealth Basic or Buy-In benefits will end on the effective date.

Enclosed with this notice is a **MassHealth Eligibility Update Form**. Please fill out the form and send it to the MassHealth Enrollment Center listed below in this notice. The information on this form will be used to decide if you are still eligible for MassHealth or not. If you answer "Yes" to any of the questions on this form, you may be eligible for MassHealth for another reason. You will get a notice if you are eligible for other benefits under MassHealth.

If you are not eligible for any other MassHealth benefits, we will send you a notice telling you when your MassHealth benefits will end.

If you answer "YES" to question 4 on the MassHealth Eligibility Update Form, you must also fill out and send us the enclosed **MassHealth Disability Supplement**. We will send the MassHealth Disability Supplement to a special unit that will decide if you qualify as disabled.

If you answer "NO" to all the questions on the MassHealth Eligibility Update Form, you do not have to send the Eligibility Update Form back to us. Your MassHealth Basic or Buy-In benefits will end on the effective date.

Also enclosed is a **MassHealth Permission to Share Information** form. You may fill out and send this form to us if you want someone else to get information about your MassHealth benefits and/or your disability status.

Please send all forms to the MassHealth Enrollment Center listed below in this notice. If you have any questions, please call the MassHealth Enrollment Center at the telephone number listed below in this notice.

<MassHealth Enrollment Center>
<MEC Street Address>
<MEC City, State, Zip>
<Toll-free 1-888-665-9993>
<TTY 1-888-665-9997 for the deaf and hard of hearing>

If you are getting a copy of this notice because you are the member's authorized representative, all the forms listed above were sent to the member only. If you need a copy of any of these forms, please contact the MassHealth Enrollment Center listed above.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance

MassHealth Eligibility Update Form

Member Information

Last name:_____ First name:_____ MI:_____

Social security number:_____ Date of birth:____/____/____

Home address: Street:_____

City:_____Zip:_____ Telephone number: (____)_____

Mailing address (if different from home address):

Street/PO Box:_____City:_____Zip:_____

Please answer the following questions below by checking "Yes" or "No," and give us all other information asked for.

1. Are you pregnant? Yes ☐ No ☐
   If yes, what is your expected due date? ___/___/____
   Are you pregnant with 1 baby?_____ twins?_____ triplets?_____If more, how many?_____

2. a) Are you a parent of a child under 19 years old who is living with you? Yes ☐ No ☐
   b) Are you a close relative caring for a child under 19 years old who is living with you and *not* living with his or her parent? Yes ☐ No ☐
   If you answered "yes" to a) or b) above, please give us the following information about this child.
   Name:_____ SSN:_____ Date of birth:___/___/____
   Sex: M ☐ F ☐ U.S. Citizen ☐ Non U.S. Citizen ☐
   Applying for MassHealth ☐ Not applying for MassHealth ☐

3. Are you HIV positive? Yes ☐ No ☐
   If "yes," you must give us proof of your HIV-positive status to continue getting MassHealth benefits. Proof can be a letter from a doctor, clinic, lab, or AIDS service provider or organization.

4. Do you have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? Yes ☐ No ☐
   If "yes," please fill out the enclosed MassHealth Disability Supplement and send it to the MassHealth Enrollment Center listed in the enclosed notice.

If you answered "YES" to any of the questions above, please send this form to the MassHealth Enrollment Center listed in the enclosed notice. If you have any questions, or have any other changes to tell us about, please call a MassHealth Enrollment Center at: 1-888-665-9993 (TTY: 1-888-665-9997 for the deaf and hard of hearing).

Your signature:_____Date:_____

Commonwealth of Massachusetts
Division of Medical Assistance
MassHealth Permission to Share Information
(DO NOT USE THIS FORM AFTER APRIL 13, 2003.)

Please fill out every item on this form. If something does not apply to you, write "DNA" (does not apply). If you leave any item blank, your permission will not be valid, and the Division of Medical Assistance will not be able to share your information with the person or group you list below.

I, _____, give my permission for the Division of Medical Assistance
(name of MassHealth applicant or member)
and those authorized to act on its behalf to share the information about me that I list below with the person or group I list below.

The Division of Medical Assistance (Division) may share the following information about me:

☐ Eligibility information and eligibility notices

☐ Disability and any other medical information

☐ Other: (please describe) _____

_____

The Division may share the above-listed information with the following person or group:

Name: _____

Organization: _____

Street address: _____

City/ state/zip: _____

Telephone number: (_____)_____

I know that the person or group listed above may be able to further share the information the Division gives them without my permission. If they do, federal privacy laws may not protect my information.

The Division may share the information I listed above for the following reasons: (If you do not want to list the reasons, just write "at my request.")

_____

_____

This permission to share my information is good until ____ / ____ / ____ (expiration date) or _____ (event).

I know that I may cancel this permission at any time. I know that if the Division has already acted on my permission, I cannot cancel my permission in that case.

I know that I do not have to sign this form. I also know that if I do not sign it, or if I cancel my permission, my MassHealth benefits will not be affected in any way.

Please send this filled-out form to the MassHealth Enrollment Center. Call 1-888-665-9993 (TTY: 1-888-665-9997 for the deaf and hard of hearing) if you have any questions.

Signature of applicant or member: _____

Print name of applicant or member: _____

Applicant's or Member's SSN (optional): _____ Date: _____